

4655

04587

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE (D.C.) Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near - Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 15x.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mason Road, R. 7, #2		d. STREET ADDRESS 4003-64th. St. (16)	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last James Rollin Adams		4. DATE OF DEATH Month Day Year May 28 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 7-1891
9. AGE (in years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Street car motorman		10b. KIND OF BUSINESS OR INDUSTRY Little Orleans, Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Edgar Adams		14. MOTHER'S MAIDEN NAME Donevara McCune	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 578-10-6559	
17. INFORMANT (wife) Florence M. Adams, Wash. D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c) ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Deming M.D.		DATE SIGNED May 29-1956	
EXAMINER'S NAME (Type) H. V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 31, 1956	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox, Cumberland, Maryland.		24a. REC'D BY REGISTRAR DATE 6/4/56	
24b. REGISTRAR'S SIGNATURE Walter R. Frantz			

MEDICAL CERTIFICATION

TO DEPUTY CITY CLERK: MINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the reason therefor. The certificate must be executed by the coroner, or by a physician, or by a funeral director. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the coroner, or to the physician, or to the funeral director. Give Page 5 to the registrar. The certificate must be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial. Cremation requires a separate permit. File pages 1 and 2 with the registrar prior to cremation.

or removal.

A15ME(5)
19/55

127
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
STATE OF NEW YORK

BUREAU V. 1

JUN 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04588

Reg. Dist. No. 8

4656

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN lb 67 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Main St.				d. STREET ADDRESS Main St.			
3. NAME OF DECEASED (Type or print) First Odilo Middle Baumann Last Baumann				4. DATE OF DEATH Month May Day 30 Year 19 56			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15-1888		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner of Restaurant & Tavern		10b. KIND OF BUSINESS OR INDUSTRY Lonaconing, Md.		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Baumann				14. MOTHER'S MAIDEN NAME Amelia Kimble			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. W.W.1 212-32-8099		17. INFORMANT Marie K. Baumann, Lonaconing, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) 						INTERVAL BETWEEN ONSET AND DEATH sudden ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H.V. Deming M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) H.V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER May 31-1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/2/1956		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, MD.				ADDRESS		24a. REC'D BY REGISTRAR DATE 6/2/56	
				24b. REGISTRAR'S SIGNATURE Jeanette M. Boal			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ADJUTANT GENERAL'S OFFICE
WASHINGTON, D. C.

BUREAU V. S.

JUN 6 1956

RECEIVED

George Washington, Washington, D. C.
June 6, 1956

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4588 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04589

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>69 Years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>517 Maryland Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Gladden</u> Last <u>Bolinger</u>				4. DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>19 56</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>March 24-1870</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Photographer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>		11. BIRTHPLACE (State or foreign country) <u>Sharpsburg, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Bolinger</u>				14. MOTHER'S MAIDEN NAME <u>Jane Shaw</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mary Bolinger, Cumberland, Md. 531 Md. Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 12-1956</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 13, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR <u>May 12, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>W. R. Frantz, M.D.</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay in execution, please enclose the certificate with the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

RECEIVED
MAY 15 1956
BUREAU V. 3

4589

CERTIFICATE OF DEATH

04590

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVE.		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) MR. CHARLES T. CALLAN		4. DATE OF DEATH Month MAY Day 16 Year 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/8/1872
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Merchant		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) MARYLAND, Little Orleans		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS CALLAN		14. MOTHER'S MAIDEN NAME Robert Carder, Hagerstown, Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Coronary Arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Uremia (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5:14 , 19 56 , to 5:16 , 19 56 , that I last saw the deceased alive on 5:16 , 19 56 , and that death occurred at 1:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. F. Williams		ADDRESS (Street, city or town, state) Cumberland Md	
PHYSICIAN'S NAME (Type) W. F. Williams, M.D.		DATE SIGNED 5-17-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/18/56	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cath. Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR May 19, 1956 W.R. Frantz, M.D.	
24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be related to the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2222

ALLIANCE

DECEASED

DATE

DECEASED

LITTLE ROCK

2/10/22

DECEASED

DECEASED

1922

2/10/22

1922

DECEASED

DECEASED

DECEASED

DECEASED

BUREAU V. S.

MAY 22 1922

RECEIVED

4590

CERTIFICATE OF DEATH

Reg. Dist. No.

DR. FAW.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE W. VA. b. COUNTY Hampshire	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) P. O. Address Little Orleans, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARION Middle C Last CAMPBELL		4. DATE OF DEATH Month MAY Day 11 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 27, 1883
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR: Months 24 Days 11 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm owner	
11. BIRTHPLACE (State or foreign country) Hyattsville, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME FRANK CAMPBELL		14. MOTHER'S MAIDEN NAME Anna MC LAUGHLIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, he or she was) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL—MEMORIAL & WARWICK AVES.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Phlebitis Common Iliac vein left. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Carcinoma breast, bilateral PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholecystitis Chronic & sub acute with stones		INTERVAL BETWEEN ONSET AND DEATH 24 hrs 1 week Apr 10/2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 1955 to May 11, 1956 , that I last saw the deceased alive on May 11, 1956 , and that death occurred at 7:15 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5 Washington St., Cumberland, Md. DATE SIGNED May 11, 56			
ACTUAL SIGNATURE Wylie M. Faw		M.D. Wylie M. Faw	
PHYSICIAN'S NAME (Type) Wylie M. Faw M.D.		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/14/56	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR May 14, 1956		24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

CERTIFICATE OF DEATH

MAINTAIN STATE DEPARTMENT OF HEALTH—EACH ONE TO

1956

DATE

BLOOD

OF

NEW YORK

DATE

WHITE

DATE

FRANK C. BELL

FRANK C. BELL

FRANK C. BELL

BUREAU V. S.

MAY 15 1956

RECEIVED

4643

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Liners Hospital</u>		d. STREET ADDRESS <u>121 Wood St.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Louis</u> Last <u>Casey</u>		4. DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 24-1873</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>02</u> Days <u>00</u> Hours <u>00</u> Min. <u>00</u>	IF UNDER 24 HRS Hours <u>00</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired line Supt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mine</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin, Id.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Patrick Casey</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ball</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>179-03-4943</u>	
17. INFORMANT <u>Mr. Charles Clark, Frostburg, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock and myocardial failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>chronic myocarditis also had bronchial asthma</u> (c) <u>several yrs.</u> DUE TO (a) stating the underlying cause lost. <u>90.2.0</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5</u> days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of left femur.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Went to get out of bed and fell to the floor.</u>	
20c. TIME OF INJURY Month, Day, Year <u>3</u> Hour <u>5-6</u> p. m. <u>1956</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Frostburg Allegany Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Downing M.D.</u>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H. V. Downing M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 11-1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-14-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst,</u>		ADDRESS <u>Frostburg, Md.</u>	
24a. REC'D BY REGISTRAR <u>5-14-56</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Harvey N. Roe</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

EDWARD R. S.

7

DR. GROVE

4591

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY MINERAL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 27 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MR. ALGIE GRAY CLISE				4. DATE OF DEATH MAY 17 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 5, 1887	9. AGE (In years last birthday) 69 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Day, house - worker Textile mill</i>				10b. KIND OF BUSINESS OR INDUSTRY WEST MARYLAND		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME <i>James K. Clise</i>				14. MOTHER'S MAIDEN NAME <i>Larrah Winters</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>212-09-5483</i>			
17. INFORMANT <i>Miss Algie Clise - Piedmont - W. Va.</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic carcinoma</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of Sigmoid colon</i> DUE TO (c) <i>5 yrs.</i>							INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>April</i> 1951, to <i>May 17</i> 1956, that I last saw the deceased alive on <i>May 17</i> 1956, and that death occurred at <i>2:15 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>D. B. Grove</i>				ADDRESS (Street, city or town, state) <i>122 S. Central Cumberland Md.</i>			
PHYSICIAN'S NAME (Type) D. B. GROVE, M.D.				DATE SIGNED <i>3-17-56</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>5/18/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Philoz Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Westernport Md</i>				22e. (State) <i>Md</i>		22f. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. J. Goral</i>				ADDRESS <i>Westernport, Maryland.</i>		24a. REC'D BY REGISTRAR <i>May 18, 1956</i>	
24b. REGISTRAR'S SIGNATURE <i>W. K. Frank, M.D.</i>				24c. (City or town)			

MEDICAL CERTIFICATION

TO HOSPITAL OR PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUCHANAN V. A.

1857

4657

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Flintstone</u>		c. LENGTH OF STAY IN b. <u>16 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural Star Rt</u>		e. STREET ADDRESS <u>Star Rt Flintstone</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First Middle Last		4. DATE OF DEATH <u>May 11</u> 19 <u>56</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 11 1862</u> 9. AGE (In years last birthday) <u>93</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own House</u>	
11. BIRTHPLACE (State or foreign country) <u>Artemas Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arson Mountain</u>		14. MOTHER'S MAIDEN NAME <u>Julizma O'Neal</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs John Davis Flintstone</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>malnutrition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerosis</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Germany</u> , 19 <u>56</u> , to <u>May 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 4</u> , 19 <u>56</u> , and that death occurred at <u>5:30 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. E. Ables</u> M.D.		ADDRESS (Street, city or town, state) <u>Hancock Md</u> DATE SIGNED <u>5/10/56</u>	
PHYSICIAN'S NAME (Type) <u></u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>May 14 1956</u>	<u>Mt Hope Cemetery</u>	<u>Artemas Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. Knight</u> ADDRESS <u>Artemas Pa</u>		24a. REC'D BY REGISTRAR <u>May 14, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Thos. J. Bender</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15 11 56

07 01 10

4544

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 106 Walnut Street				d. STREET ADDRESS Walnut Street			
3. NAME OF DECEASED (Type or print) First Middle Last CLARENCE COOK				4. DATE OF DEATH Month Day Year May 26, 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-8-1880	9. AGE (In years last birthday) yrs. 75	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired-print plant				10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Frostburg, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Cook				14. MOTHER'S MAIDEN NAME Martha Mirrick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO 214-07-1916			
17. INFORMANT Harry Cook, Frostburg, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, Cerebral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Epilepsy, Grand Mal DUE TO (c) Chronic Pulmonary						INTERVAL BETWEEN ONSET AND DEATH 20 yrs 10 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 134 E Main Frostburg, Md	
20f. (City or town) Frostburg				20g. (County) Frostburg		20h. (State) Md.	
21. I certify that I attended the deceased from MAY 1955 , to MAY 26, 1956 that I last saw the deceased alive on MAY 25, 1956 , and that death occurred at 5:30 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John C. Durst				ADDRESS (Street, city or town, state) 134 E Main Frostburg, Md			
PHYSICIAN'S NAME (Type) John C. Durst M.D.				DATE SIGNED 5/28/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-29-1956		22c. NAME OF CEMETERY OR CREMATORY F'b'g. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.				24a. REC'D BY REGISTRAR 5-28-56		24b. REGISTRAR'S SIGNATURE Wm. Hawley N. Rye	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAY 19 1900

RECEIVED
MAY 19 1900

DR. VAN ORMER

4592

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE WEST VIRGINIA b. COUNTY HARDY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 4 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS MOOREFIELD			
3. NAME OF DECEASED (Type or print) First ADAM Middle CRITES, SR. Last				4. DATE OF DEATH Month MAY 17, Day 19 Year 56			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 24, 1895	
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING				10b. KIND OF BUSINESS OR INDUSTRY Rented a farm		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CHARLES CRITES				14. MOTHER'S MAIDEN NAME JANE OURS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 236-48-2954		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 299X IMMEDIATE CAUSE (a) Thrombo-cytopenic Purpura, DUE TO secondary to aplastic bone marrow Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6 weeks DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 13 May, 1956 to 17 May, 1956 that I last saw the deceased alive on 16 May 56 , 19 56 , and that death occurred at 4:15A M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Alfred Van Ormer M.D.				ADDRESS (Street, city or town, state) 22 S. Centre St. Cumberland, Md. DATE SIGNED 17 May 56			
PHYSICIAN'S NAME (Type) W. Alfred Van Ormer, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 19, 1956		22c. NAME OF CEMETERY OR CREMATORY Newhouse Cemetery		22d. LOCATION (City, town, or county) (State) near Rig, West Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE P. E. Shush & Son				ADDRESS Moorefield, W. Va.		24a. REC'D BY REGISTRAR May 18, 1956	
				24b. REGISTRAR'S SIGNATURE W. L. Trout, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

LIBRARY

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4593 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04597

Reg. Dist. No.

4

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>30 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>111 Fifth St.</u>				d. STREET ADDRESS <u>111 Fifth St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>Gibson</u> Last <u>Crites</u>				4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April-11-1880</u>	9. AGE (In years last birthday) <u>76</u> yrs.	FUNERAL YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Morefield, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Crites</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ann</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>(son) Ernest Crites, Robert St. Cumberland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> <u>453.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic myocarditis</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H.V. Dering M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H.V. Dering M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 5-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 7, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Davis Memorial Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>May 5, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>H.K. Trantz, M.D.</u>	

RECEIVED
AY 7 1956
BUREAU V. S.

4594

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04598

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(rur l) Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.C.A. at the Memorial Hospital</u>				d. STREET ADDRESS <u>St. 3 Bowmans Addition</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rosie</u> Middle <u>Didawick</u> Last <u>Didawick</u>				4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 6-1922</u>		9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Rosie Foreman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>St. 3 Bowmans Addition</u> <u>(husband) John W. Didawick, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>several years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 12-1956</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 22, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Abe Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>near Ridgeley, West Virginia.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>May 19, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Frank, M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2-10-1914

MAY 5

1-10-1914

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4595
CERTIFICATE OF DEATH

04599

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 16 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONACONING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS CASTLE HILL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE First Middle Last J. DONALD			4. DATE OF DEATH Month MAY Day 31 Year 1956				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1883 APRIL 22, 1883	9. AGE (In years last birthday) 73 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mines		11. BIRTHPLACE (State or foreign country) FROSTBURG, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN DONALD				14. MOTHER'S MAIDEN NAME CATHERINE HINEBAUGH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lymphatic Leukemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Artery Disease. Old Post-infarction				INTERVAL BETWEEN ONSET AND DEATH Several Months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5:15 , 19 56 to 5:31 , 19 56 , that I last saw the deceased alive on 5:25 , 19 56 , and that death occurred at 8 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE M. Z. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 5:31:56			
PHYSICIAN'S NAME (Type) DR. W.E. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 3, 1956		22c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		22d. LOCATION (City, town, or county) (State) Westernport, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George Eukhorn				ADDRESS Lomaccony Md		24a. REC'D BY REGISTRAR June 4, 1956	
				24b. REGISTRAR'S SIGNATURE W.L. Frantz, M.D.			

TO HOSPITAL OR TO FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURTON H. R.

4658

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Cumberland, rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastman Road, M-24				d. STREET ADDRESS Eastman Road, M-24			
3. NAME OF DECEASED (Type or print) First Middle Last SARAH VIRGINIA ECKARD				4. DATE OF DEATH Month Day Year May 11, 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1871		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Petersburg, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME ? Wolford				14. MOTHER'S MAIDEN NAME Unobtainable			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Orville Blubaugh Rt. # 2 Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Maemia 4.2.2 DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 wks 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May 1, 1956 , to May 11, 1956 , that I last saw the deceased alive on May 1, 1956 , and that death occurred at 3:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5/11/56 DATE SIGNED							
ACTUAL SIGNATURE Clay E. Durrett M.D.				236 Virginia Ave.			
PHYSICIAN'S NAME (Type) Clay E. Durrett M. D.				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/13/56		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR May 12, 1956	
				24b. REGISTRAR'S SIGNATURE W.R. Hunt, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1, 2, and 3 of this certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 3 from the certificate and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D.C.

8 11 11

25 11 32

11 11 11

DR. DURRETT ~~Will be corporate limit~~ CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 HRS. 55 MIN.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. STREET ADDRESS 524 FRANK'S LANE	
3. NAME OF DECEASED (Type or print) First EDNA Middle E Last EVANS		4. DATE OF DEATH Month MAY Day 20 Year 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 8, 1902
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH C. STEWART		14. MOTHER'S MAIDEN NAME LAURA WILKES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right Massive Cerebral Hemorrhage DUE TO Left Hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension (c) Hypertension INTERVAL BETWEEN ONSET AND DEATH 5 hrs 5 hrs 6 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 19, 1956 to May 20, 1956 that I last saw the deceased alive on May 19, 1956 , and that death occurred at 12:25 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clay E. Durrett M.D.		ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 5/20/56	
PHYSICIAN'S NAME (Type) Clay E. Durrett			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried	22b. DATE THEREOF 5-23-56	22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE 5/23/56 24b. REGISTRAR'S SIGNATURE W. P. F. ... MD	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove, carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A

MAY 28 1951

RECEIVED
MAY 28 1951

4645

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg 22			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 211 Welsh Hill				d. STREET ADDRESS 211 Welsh Hill			
3. NAME OF DECEASED (Type or print) First JENNIE Middle EVANS Last EVANS				4. DATE OF DEATH Month May Day 26 Year 1956			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-10-1882	9. AGE (In years lost birthday) yrs 74	IF UNDER 1 YEAR Months 7 Days 4 Hours 14 Min.		IF UNDER 24 HRS Months 7 Days 4 Hours 14 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN ANDERSON				14. MOTHER'S MAIDEN NAME EMILY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none		17. INFORMANT Russell Evans, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Rheumatoid Arthritis 7-2-56 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Failure DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 30 yrs. 1 yr
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 1956 to May 26, 1956 , that I last saw the deceased alive on May 26, 1956 , and that death occurred at 2 A. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 134 E. Main DATE SIGNED 5/28/56 ACTUAL SIGNATURE John C. Durst M.D. Frostburg, Md. PHYSICIAN'S NAME (Type) John C. Durst							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-28-1956		22c. NAME OF CEMETERY OR CREMATORY F'b'g. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.				24a. REC'D BY REGISTRAR 5-28-56		24b. REGISTRAR'S SIGNATURE Wm. Harvey N. Roe	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE PATENT

1956

W. A. R.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04604

DR. WHITWORTH

4598

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a STATE MARYLAND b COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near CUMBERLAND, rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First BOY Middle FILES Last FILES		4. DATE OF DEATH Month MAY Day 25 Year 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MAY 25, 1956
9 AGE (In years last birthday) yrs. 1		IF UNDER 1 YEAR Months 1 Days 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WALTER F. FILES		14. MOTHER'S MAIDEN NAME NORMA G. ROBINETTE	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17 INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity, etc. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Fuller B. Whitworth, M.D.			
PHYSICIAN'S NAME (Type) Fuller B. Whitworth, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF May 26, 1956	22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital	22d LOCATION (City, town, or county) (State) Cumberland, Maryland.
23 FUNERAL DIRECTOR'S SIGNATURE Memorial Hospital, Cumberland, Maryland/		24a REC'D BY REGISTRAR May 25, 1956 24b. REGISTRAR'S SIGNATURE W. K. Francis, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the bottom papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 28 1930

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										04605
Within corporate limits 4593 CERTIFICATE OF DEATH										Reg. Dist. No. 4
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>					c. LENGTH OF STAY IN 1b <u>72 yrs.</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland, Md.</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>210 Thomas Street</u>					d. STREET ADDRESS <u>210 Thomas Street</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Frances</u> Last <u>Brady</u>					4. DATE OF DEATH Month <u>5</u> Day <u>7</u> Year <u>1955</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 6, 1875</u>		9. AGE (In years last birthday) <u>81</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>County Gl., Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael Hayes</u>					14. MOTHER'S MAIDEN NAME <u>Mary ?</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Pearl Andrews, Cumberland, Md.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerotic heart disease</u> DUE TO (c) <u>atherosclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>1 year</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-3-</u> 19 <u>52</u> , to <u>5-7-</u> 19 <u>56</u> , that I last saw the deceased alive on <u>5-4-</u> 19 <u>56</u> , and that death occurred at <u>11 P. M.</u> from the causes and on the date stated above										
ACTUAL SIGNATURE <u>L. M. [Signature]</u>					ADDRESS (Street, city or town, state) <u>57 Queen St., Cumberland, Md.</u>					DATE SIGNED <u>5-9-56</u>
PHYSICIAN'S NAME (Type)										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>May 11, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Terra Alta Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Terra Alta, W. V.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. M. F. [Signature]</u>					ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>May 11, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. [Signature]</u>	

MEDICAL CERTIFICATION

BUREAU Y. S.

MAY 14 1956

RECEIVED

4600

CERTIFICATE OF DEATH

DR. MIRKIN

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE W. VA. b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HALLIE Middle FERN Last FRIEND		4. DATE OF DEATH Month MAY Day 11 Year 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH M JAN. 30, 1917
9. AGE (In years last birthday) 39 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator - Perfection Garment Co.		10b. KIND OF BUSINESS OR INDUSTRY W.VA.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS KISNER		14. MOTHER'S MAIDEN NAME DELSIE TICHNELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service No		16. SOCIAL SECURITY NO. 234-44-7007	
17. INFORMANT MEMORIAL HOSPITAL-MEMORIAL & WARWICK AVES.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary carcinoma of liver 155X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 months		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 9 , 19 56 , to MAY 11 , 19 56 , that I last saw the deceased alive on MAY 11 , 19 56 , and that death occurred at 4:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 115 So. Centre St. Cumberland Md. DATE SIGNED 5/14/56			
ACTUAL SIGNATURE A. J. MIRKIN M.D.		PHYSICIAN'S NAME (Type) A. J. MIRKIN	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 14, 1956	
22c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		22d. LOCATION (City, town, or county) (State) near Terra Alta, West Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE Markwood Funeral Home, Keyser, West Virginia.		24a. REC'D BY REGISTRAR May 14, 1956 24b. REGISTRAR'S SIGNATURE W. L. Frank, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 7 0 0 0 0

90 1

17 1 1 1 1 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4646 CERTIFICATE OF DEATH

04607

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS 66 Bowery St.			
3. NAME OF DECEASED (Type or print) First OLIN Middle GUNNETT Last GUNNETT				4. DATE OF DEATH Month May Day 22 Year 19 56			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-17-1876		9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Kelly-Spgfd. Tire		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Madison Gunnett				14. MOTHER'S MAIDEN NAME Ann Bowen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-12-89064		17. INFORMANT Mrs. Olin Gunnett, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 272.X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 13 days ?							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 0. 11. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-9-11-1952 , to May 22, 1956 , that I last saw the deceased alive on May 22, 1956 , and that death occurred at 3:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frostburg Md. DATE SIGNED May 23 1956							
ACTUAL SIGNATURE WOM Lane M.D.				PHYSICIAN'S NAME (Type) WOM Lane MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-25-56		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR 525-56	
				24b. REGISTRAR'S SIGNATURE Wm. Nancy N Roe			

BUREAU V. S.

1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04608

DR. VAN ORMER

4601

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY GRANT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN lb 18 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS PETERSBURG			
3. NAME OF DECEASED (Type or print) First JANE Middle HARTMAN Last				4. DATE OF DEATH Month MAY Day 11 Year 1956			
5 SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> D.VORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 4, 1871		9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MATTHEW COLLINS				14. MOTHER'S MAIDEN NAME RACHEAL MICK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Gall-bladder, primary DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 3	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia, at. Lower lobe						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 25 Apr. 56 , 19 56 , to 11 May , 19 56 that I last saw the deceased alive on 10 May , 19 56 , and that death occurred at 12:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. A. Van Ormer		M.D. Cumberland, Md.		ADDRESS (Street, city or town, state)		DATE SIGNED 11 May 56	
PHYSICIAN'S NAME (Type) W. A. VAN ORMER, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 13, 1956		22c. NAME OF CEMETERY OR CREMATORY Maple Hill Cemetery		22d. LOCATION (City, town, or county) (State) Petersburg, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Schaeffer Funeral Home, Petersburg, W. Va.				ADDRESS		24a. REC'D BY REGISTRAR May 12, 1956	
				24b. REGISTRAR'S SIGNATURE W. K. Hanky, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED 7. 8.

MAY

RECEIVED 7. 8.

CERTIFICATE OF DEATH

Reg. Dist. No.

4659

Outside of City Limits

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician. After this certificate has been signed by the attending physician and completely filled in by the local director of health, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Pinto, Md.		c. LENGTH OF STAY IN 1b 39yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Pinto, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION McMullen Highway		d. STREET ADDRESS McMullen Highway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Helmick		4. DATE OF DEATH Month May Day 24 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 5, 1880	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Denton, Md.	
13. FATHER'S NAME Charles S. Smith		14. MOTHER'S MAIDEN NAME Adeline *****		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT Carlton Helmick McMullen Highway, Pinto, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Arterio 45A DUE TO Sclerotic Cardio Vascular Dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aneurysm of thoracic aorta					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 3. 6. 19 43 to 5. 24 19 56 , that I last saw the deceased alive on 5. 21. 19 56 , and that death occurred at 8 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland Md. DATE SIGNED 5-25-56 ACTUAL SIGNATURE W. F. Williams M.D. PHYSICIAN'S NAME (Type) W. F. Williams, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 27, 1956		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetary	
22d. LOCATION (City, town, or county) Cumberland, Md.		22e. REC'D BY REGISTRAR May 26, 1956 W. F. Frank, M.D.		22f. REGISTRAR'S SIGNATURE	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.			

BUREAU V. S.

MAY 1900

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04610

DR. TOPPER

4502

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 20 MIN.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 719 SYLVAN AVENUE			
3. NAME OF DECEASED (Type or print) First JOHN Middle B. Last HENRY				4. DATE OF DEATH Month MAY Day 6 Year 1956			
5 SEX MALE	6. COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Mar 4, 1895		9. AGE (In years last birthday) 61 yrs.	10 UNDER 1 YEAR Months Days Hours	11 UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER - CITY OF CUMBERLAND				10b. KIND OF BUSINESS OR INDUSTRY WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID A. HENRY				14. MOTHER'S MAIDEN NAME LULA F. HESSER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH One hour						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr 15, 1956 , to May 6, 1956 , that I last saw the deceased alive on May 6, 1956 , and that death occurred at 5:10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John H. Topper M.D.				ADDRESS (Street, city or town, state) Allegany Co. Maryland			
PHYSICIAN'S NAME (Type) John A. Topper				DATE SIGNED 5/6/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/9/56		22c. NAME OF CEMETERY OR CREMATORY St. Olive Meth. Cem		22d. LOCATION (City, town, or county) (State) Allegany Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Mafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR May 9, 1956		24b. REGISTRAR'S SIGNATURE W. L. W. M.D.	

BUREAU V. S.

MAY 10 1900

RECEIVED

4603

CERTIFICATE OF DEATH

Reg. Dist. No.

04611

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 65 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 641 LINCOLN STREET	
3. NAME OF DECEASED (Type or print) First NELLIE Middle I Last HENRY		4. DATE OF DEATH Month 5- Day 2 Year 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 19, 1989
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own House	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM BRANT		14. MOTHER'S MAIDEN NAME SARAH SHIELDS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT William Henry, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis - uremia DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intestinal obstruction DUE TO Very bad prolapse bladder (c) late 30's treated for carcinoma of cervix		INTERVAL BETWEEN ONSET AND DEATH One week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) late 30's treated for carcinoma of cervix		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-28, 1951 to 5-2-1956 that I last saw the deceased alive on 5-1-1956 and that death occurred at 7:35 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm. A. Williams		ADDRESS (Street, city or town, state) Cumberland	
DATE SIGNED 5-3-56			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 4 1956	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. A. Williams		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR May 4, 1956		24b. REGISTRAR'S SIGNATURE Wm. A. Williams, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BOMBAU V. S.

REC-111

4604 CERTIFICATE OF DEATH

04612

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 607 Sedgewick St.,		d. STREET ADDRESS 607 Sedgewick St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THERESA Middle FRANCES Last HESKETT		4. DATE OF DEATH Month May Day 17 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1895
9. AGE (In years last birthday) 61 yrs		10. IF UNDER 1 YEAR: Months 17 Days 19 Hours 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Turners Falls, Mass.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Dennis J. O'Leary		14. MOTHER'S MAIDEN NAME Lucy Murphy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Charles Z. Heskett		Address 607 Sedgewick St., Cumb. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordial arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension and Coronary Heart Disease DUE TO (c) with coronary insufficiency		INTERVAL BETWEEN ONSET AND DEATH 4 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 20 August , 19 52 , to 17 May , 19 56 , that I last saw the deceased alive on 30 Apr. , 19 56 , and that death occurred at 6:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 122 So. Centre St., DATE SIGNED ACTUAL SIGNATURE W. Alfred Van Ormer M.D. PHYSICIAN'S NAME (Type) W. A. VanOrmer M. D. Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/19/56	22c. NAME OF CEMETERY OR CREMATORY Philos Cemetery	22d. LOCATION (City, town, or county) (State) Westernport, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR May 19, 1956 R. Frank, M.D.		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURTON V. S.

MAY

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04613

4695

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY BEDFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 1 DAY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS HYNDMAN			
3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last HOLLER				4. DATE OF DEATH Month MAY Day 16 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 16, 1956	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS Days		Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EARL RAYMOND HOLLER				14. MOTHER'S MAIDEN NAME BETTY VIRGINIA COOK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurely</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 11 1/2 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-16 , 19 56 , to 5-16 , 19 56 , that I last saw the deceased alive on 5-16 , 19 56 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 441 N. Centre St. Md. DATE SIGNED 5-17-56							
ACTUAL SIGNATURE <i>William P. James</i>		M.D. <i>William P. James</i>		Cumberland		Md.	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 5/17/56		22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Memorial Hosp, Cumberland, Md.</i>				24a. REC'D BY REGISTRAR <i>W. R. Frank, M.D.</i>			
ADDRESS				24b. REGISTRAR'S SIGNATURE			



U.S.

RECEIVED

4606

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 1 DAY		
d. NAME OF HOSPITAL, HOME, OR INSTITUTION MEMORIAL & WARWICK AVES			d. STREET ADDRESS M-24, EASTMAN ROAD		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First GRAYSON Middle ODELL Last HOUSEHOLDER			4. DATE OF DEATH Month MAY Day 12 Year 1956		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1904 SEPT. 3, 1904		9. AGE (In years last birthday) 51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) W. VA.	
13. FATHER'S NAME JAMES G. HOUSEHOLDER			14. MOTHER'S MAIDEN NAME SALOMA PEER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes Air Force			16. SOCIAL SECURITY NO. 220-10-4964		
17. INFORMANT Harry O. Householder, Cumberland, Md.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 1400.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 24 hrs 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. — 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/4/56 , 19 to 5/12/56 , 19, that I last saw the deceased alive on 5/12/56 , 19, and that death occurred at 8:20 AM , from the causes and on the date stated above.					
ACTUAL SIGNATURE R. J. Williams M.D.			ADDRESS (Street, city or town, state) Cumberland, Md.		
PHYSICIAN'S NAME (Type) R. J. Williams			DATE SIGNED 5/13/56		
22a. BURIAL, CREMATION, REMOVAL (Specify) buried		22b. DATE THEREOF May 15, 1956	22c. NAME OF CEMETERY OR CREMATORY Baptist Cemetery		22d. LOCATION (City, town, or county) (State) Three Churches, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarielli, Cumberland, Md.			24a. REC'D BY REGISTRAR May 14, 1956		
			24b. REGISTRAR'S SIGNATURE W. L. Frank, M.D.		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

17000

4647

CERTIFICATE OF DEATH

04615

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle FRANCIS Last HUGHES		4. DATE OF DEATH Month 5 /18/1956 Day 19 Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/1/1874
9. AGE (In years last birthday) 81 yrs		IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min	IF UNDER 24 HRS Months 10 Days 10 Hours 10 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	11. BIRTHPLACE (State or foreign country) Ireland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Hughes	
14. MOTHER'S MAIDEN NAME Mary Ann Wilson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 217-05-6605		17. INFORMANT Mrs. Annie McGowan Hughes Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis DUE TO Diverticulitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diverticulitis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5-9 , 19 56 , to 5-18 , 19 56 , that I last saw the deceased alive on 5-18 , 19 56 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Leslie R. Miles, Jr. M.D. Lonaconing, Md.		PHYSICIAN'S NAME (Type) Leslie R. Miles, Jr., M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/21/1956	22c. NAME OF CEMETERY OR CREMATORY St. Michael Cemetery, Frostburg, MD.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, MD.		24a. REC'D BY REGISTRAR DATE 5-21-56	24b. REGISTRAR'S SIGNATURE Mrs. Nancy H. Rose

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AV 20 1900

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4507 CERTIFICATE OF DEATH

Reg. Dist. No. 04616

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 2/9/50		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary			d. STREET ADDRESS 133 Hanover Street		
3. NAME OF DECEASED (Type or print) First Jessie Middle Russel Last Hutcheson			4. DATE OF DEATH Month May Day 30 Year 19 56		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/26/1872		9. AGE (In years last birthday) 84 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME John Whitefield			14. MOTHER'S MAIDEN NAME Elizabeth Jackson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT Address P.O.Box 599 Allegany County Infirmary Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostases 12-2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Nephritis DUE TO (c) Cerebral arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH 48 hrs ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Incisional Hernia					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 2/9/50 , 19____, to 5/30/56 , 19____, that I last saw the deceased alive on 5/30/56 , 19____, and that death occurred at 12:00PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE James E. McLean		ADDRESS (Street, city or town, state) 49 Greene St.		DATE SIGNED 5/31/56	
NAME (Type) Dr. James E. McLean		Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 3, 1956	22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Maryland.		ADDRESS June 1, 1956		24b. REGISTRAR'S SIGNATURE W. H. Kight, M.D.	

3

3

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6 Virginia Ave.,		d. STREET ADDRESS 6 Virginia Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SARAH Middle CATHERINE Last INSKEEP		4. DATE OF DEATH Month May Day 17, Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1872
9. AGE (In years last birthday) 84 yrs		IF UNDER 1 YEAR: Months 17, Days 19 Hours 56 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Capon Bridge, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Mallon Pugh		14. MOTHER'S MAIDEN NAME Rebecca J. Nixon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No, (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Elizabeth Pugh 6 Virginia Ave., Cumb. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 452.1 Uraemia DUE TO (b) Myocarditis DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 wks. 6 yrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 50 , to May 17, 19 56 ; that I last saw the deceased alive on May 15, 19 56 , and that death occurred at 7:00A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 236 Virginia Ave., DATE SIGNED ACTUAL SIGNATURE Clay E. Durrett M.D. NAME (Type) Clay E. Durrett M.D. Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/20/56	
22c. NAME OF CEMETERY OR CREMATORY Queens Point Cem.		22d. LOCATION (City, town, or county) (State) Keyser, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George Cumberland, Md.		24a. REC'D BY REGISTRAR May 19, 1956 24b. REGISTRAR'S SIGNATURE W. L. Frank, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1950

10

4699 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>Rt. 6</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>William</u> Last <u>Judy</u>				4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1900</u>		9. AGE (In years last birthday) <u>56</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>		11. BIRTHPLACE (State or foreign country) <u>Petersburg, W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George A. Judy</u>				14. MOTHER'S MAIDEN NAME <u>Alice Hedrick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214 05 8758</u>		17. INFORMANT <u>Mrs. Catherine Judy Rt. 6 Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Hypertensive Cardio-Vascular Disease</u> <u>440X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>54</u> , to <u>May 21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 21</u> , 19 <u>56</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>John L. Topper</u> M.D.				DATE SIGNED <u>Hyndman</u>			
PHYSICIAN'S NAME (Type) <u>John A. Topper</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-24-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HillCrest Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u> ADDRESS <u>Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>May 25, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. K. Hantz, M.D.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 1

RECEIVED

4648

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kookon Nurseing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Morgan Middle Keplinger Last		4. DATE OF DEATH Month 5/28/1956 Day 19 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 23, 1898
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lonaconing, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Keplinger		14. MOTHER'S MAIDEN NAME Hulda Trenam	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Ella Starkey, Lonaconing, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 56 to May 28, 1956 , that I last saw the deceased alive on May 28, 1956 , and that death occurred at 8 A. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Piedmont W. Va DATE SIGNED 5-27-56 ACTUAL SIGNATURE James H. W. Va M.D. PHYSICIAN'S NAME (Type) J. H. Wolverton Jr M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/30/1956	
22c. NAME OF CEMETERY OR CREMATORY Old Coney Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, MD.		24a. REC'D BY REGISTRAR DATE 5-31-56	
24b. REGISTRAR'S SIGNATURE Mrs. Gene Kelly			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUTLER A. E.

1906

17

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4610

CERTIFICATE OF DEATH

04620

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>UMBERLAND</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>UMBERLAND</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>426 Furnace St</u>				d. STREET ADDRESS <u>426 Furnace St</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Lee Kirby</u>				4. DATE OF DEATH Month Day Year <u>May 18 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 1 1889</u>	
9. AGE (In years last birthday) <u>66</u> yrs		IF UNDER 1 YEAR: Months Days Hours Min		IF UNDER 24 HRS: Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee of City Engineering Dept</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William F Kirby</u>				14. MOTHER'S MAIDEN NAME <u>Annie Paul</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes War I</u>				16. SOCIAL SECURITY NO. <u>214-05-9181</u>			
17. INFORMANT <u>Mrs Anna Kirby - (Cumberland)</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>Coronary Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3-29</u> , 19 <u>56</u> , to <u>5-18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-18</u> , 19 <u>56</u> , and that death occurred at <u>4:13 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ralph W. Ballin</u> M.D.				ADDRESS (Street, city or town, state) <u>62 Greene St Cumberland</u>			
PHYSICIAN'S NAME (Type) <u>Ralph W. Ballin, M.D.</u>				DATE SIGNED <u>5-21-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>5/21/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Lukes Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Cumberland Md</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>				ADDRESS <u>Cumberland</u>		24a. REC'D BY REGISTRAR <u>May 21, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>W.R. Frantz, M.D.</u>							

DONALD A. B.

1956

1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4660

CERTIFICATE OF DEATH

04621

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>6 Cumberland, Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>6 Cumberland, Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Bowling Green</u>				d. STREET ADDRESS <u>Bowling Green, R. 1, D. 2</u>			
3. NAME OF DECEASED (Type or print) First <u>KARL</u> Middle <u>DICKEY</u> Last <u>KOLSETH</u>				4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 25, 1892</u>	
9. AGE (In years last birthday) yrs <u>63</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>19</u> Hours <u>56</u>		IF UNDER 24 HRS. Months <u>3</u> Days <u>19</u> Hours <u>56</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Jockey agent</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Racing</u>		11. BIRTHPLACE (State or foreign country) <u>Summerville, Mass.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>							
13. FATHER'S NAME <u>Harry L. Kolseth</u>				14. MOTHER'S MAIDEN NAME <u>Clara Estes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Helen Kolseth R. D. # 6 Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cause of the lungs</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>metastatic cancer of the lungs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u>56</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>57 Greene St.</u>				20g. (County) <u>Cumberland</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>5-1-</u> 19 <u>56</u> , to <u>5-2-</u> 19 <u>56</u> , that I last saw the deceased alive on <u>5-2-</u> 19 <u>56</u> , and that death occurred at <u>9:15 A. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lewis Brings</u>				DATE SIGNED <u>May 5, 1956</u>			
PHYSICIAN'S NAME (Type) <u>Lewis Brings M.D.</u>				CUMBERLAND, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/5/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>S. S. Peter & Psul's</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u>				ADDRESS <u>Cumberland, Maryland</u>			
24a. REC'D BY REGISTRAR <u>May 5, 1956</u>				24b. REGISTRAR'S SIGNATURE <u>W. L. Brings M.D.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAY 9
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04622

4649 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE MD.		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Frostburg				TOWN Frostburg			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
14 Grant Street				14 Grant Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Christopher (Middle) (Last) Krauss				(Month) (Day) (Year) 5/28/1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR (If UNDER 24 HRS. Months Days Hours Min.)		
Male	White	Married	Feb. 13th 1873	83 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired Miner		Coal Mine		Frostburg, MD.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Henry Krauss				Martha E. Lemart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		215-20-6569		Mrs. George Rendar, Frostburg, MD			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION (Daughter)		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A)				CORONARY ARTERY HEART DISEASE		2 YRS. 12	
ANTECEDENT CAUSE(S) DUE TO (B)				ARTERIOSCLEROSIS		20 YRS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
NONE		NONE					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>		NONE					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5/2 , 19 56 , to MAY 28 , 19 56 , that I last saw the deceased alive on MAY 25 , 19 56 , and that death occurred at 2:00 P.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
John J. Rendar		M.D. 48 Broadway - Frostburg, Md.		5/29/56			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		5/31/1956		German Luthern Cemetery, Frostburg, MD.			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
5-31-56		Mr. Harvey N. Roe		George Eichhorn, Lonaconing, MD.			

EDWARD A. F.

1950

EDWARD A. F.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M-1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04623

4650

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>ALLEGANY</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>FROSTBURG</u>		LENGTH OF STAY (in this place) <u>6 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>MT. SAUSAGE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MINERS HOSPITAL</u>				STREET ADDRESS (If rural, give location) <u>Church Hill</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MARY AGNES Kuhlman</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 3 1956</u>			
5. SEX <u>Female</u> COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>		8. DATE OF BIRTH <u>7-11-1903</u>		9. AGE last birthday <u>52</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWORK</u>		11. BIRTHPLACE (State or foreign country) <u>MT. SAUSAGE, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George Adam Kuhlman</u>				14. MOTHER'S MAIDEN NAME <u>Adaline RARRICK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mary M. Kuhlman, MT. SAUSAGE, MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1. IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						<u>1 day</u>	
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiovascular Diseases</u>						<u>years -</u>	
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerosis</u>						<u>years -</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 53</u> , 19 <u>53</u> , to <u>May 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 3</u> , 19 <u>56</u> , and that death occurred at <u>12:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Solomon B. Davis</u>		M.D.		ADDRESS (Street, city, town, state) <u>Frostburg, Md.</u>		DATE SIGNED <u>5/5/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>MAY 7, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>ST. PATRICKS CEMETERY</u>		LOCATION (City, town, or county) (State) <u>MT. SAUSAGE MD</u>	
24. REC'D BY REGISTRAR <u>5-6-56</u>		REGISTRAR'S SIGNATURE <u>Wm. Nancy N. Rae</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HARVEY H. Zeigler</u>		ADDRESS <u>PA Hyndman</u>	



SHAW V. 1



Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4611

CERTIFICATE OF DEATH

04624

Reg. Dist. No.

4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 11/7/52	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Herbert Middle W. Last Langham		4. DATE OF DEATH Month May Day 7 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/4/1875
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Langham		14. MOTHER'S MAIDEN NAME Susanah Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Address P. O. Box 599		Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Pulmonary Hypostasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) Cerebral Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Special arthritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/7/52 , 19 to 5/7/56 , 19, that I last saw the deceased alive on 5/7/56 , 19, and that death occurred at 1:15A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene Street DATE SIGNED May 7, 1956	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 9, 1956	22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery	22d. LOCATION (City, town, or county) (State) Moscow, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ellsworth S. Boal, Westernport, Maryland.		24a. REC'D BY REGISTRAR May 9 1956	24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.

BUREAU V. S.

MAY 10 1954

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4612 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04625

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chamberland</u>				c. LENGTH OF STAY IN 1b <u>11 hrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Meyersdale, rural</u> <u>15 X-3</u>			
f. STREET ADDRESS <u>Route #3</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William H. Legas</u>				4. DATE OF DEATH Month Day Year <u>May 23 1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 9-1920</u>	9. AGE (In years last birthday) <u>36</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Engineering Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Indian Head, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Legas</u>				14. MOTHER'S MAIDEN NAME <u>Anna Kane</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>U.S. 2 205-16-0446</u>		17. INFORMANT Address <u>Memorial Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural epidural hemorrhage</u> <u>12.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>a fractured skull also had fractured 3rd</u> DUE TO (c) <u>rib (left) post occipital laceration of scalp.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>11 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell about 20 ft. through hole in floor, head struck water</u>					
20c. TIME OF INJURY Month, Day, Year <u>May 23 1956</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Pitt. Plate Co. Chamberland</u>		20f. (City or town) (County) (State) <u>North Branch</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Denning M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Denning M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 23-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 26, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Meyersdale, Pennsylvania.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Konhaus Funeral Home, Meyersdale, Pennsylvania</u>				24a. REC'D BY REGISTRAR <u>May 25, 1956 W. L. Trant, M.D.</u>		24b. REGISTRAR'S SIGNATURE	

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PA-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAY 28 1950

BUREAU V. S.

RECEIVED

DR. DURRETT

4613

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 337 VIRGINIA AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AUGUST Middle LINDEMAN Last		4. DATE OF DEATH Month MAY Day 30 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 1, 1881
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Machinist's Helper - Steel		10b. KIND OF BUSINESS OR INDUSTRY STEEL	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN LINDEMAN		14. MOTHER'S MAIDEN NAME CYNTHIA LEASURE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 3 wks 3 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1954 to May 30, 1956 that I last saw the deceased alive on May 29, 1956 , and that death occurred at 1:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clay E. Durrett M.D.		ADDRESS (Street, city or town, state) Cumberland	
DATE SIGNED 5/31/56			
PHYSICIAN'S NAME (Type) Clay E. Durrett, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 2, 1956	22c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland.		24a. REC'D BY REGISTRAR May 31, 1956	
		24b. REGISTRAR'S SIGNATURE W. Frank, M.D.	

MEDICAL CERTIFICATION

TO CENTRAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



461

4614 **CERTIFICATE OF DEATH**

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>2 mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frostburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat</u>				STREET ADDRESS (If rural give location) <u>14 Lee St.</u>			
3. NAME OF DECEASED (Type or Print) <u>Francis</u> (First) <u>Markey</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>May</u> (Day) <u>25</u> (Year) <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>9-8-1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>K. of C. Lodge</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Francis Markey</u>				14. MOTHER'S MAIDEN NAME <u>Bridget O'Neil</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-03-6923A</u>		17. INFORMANT & ADDRESS <u>Walter Yungerman, Frostburg, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Pulmonary Hypostasis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Hemorrhage</u>				<u>1 wk</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic Myocarditis</u>				<u>?</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Naive Depressive Psycho</u>				<u>3 yrs.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u> </u> <u> </u> <u> </u> <u> </u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 26</u> , 19 <u>56</u> , to <u>May 25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 24</u> , 19 <u>56</u> , and that death occurred at <u>1:15</u> M. from the causes and on the date stated above. SIGNATURE <u>James B. McLean</u> M.D. ADDRESS (Street, city, town, state) <u>49 Green St. Cumberland 32556</u> DATE SIGNED <u>May 26, 1956</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-28-56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR <u>May 26, 1956</u>		REGISTRAR'S SIGNATURE <u>W. R. Frank, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst, Frostburg, Md.</u>			

Within 24 hours after death

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M.

BUREAU V. S.

MAY 20 1934

RECEIVED

DR. SIMONS.

4615 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE W. VA. b. COUNTY Berkley	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERKLEY SPRINGS, XM	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CORA Middle I Last MC CUMBE		4. DATE OF DEATH Month MAY Day 11 Year 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 3 1871
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR: Months 11 Days 11 Hours 11 Min 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DANIEL YOUNG		14. MOTHER'S MAIDEN NAME ROZELLA KING	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO None	
17. INFORMANT MEMORIAL HOSPITAL-MEMORIAL & WARWICK AVES.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal bleeding cause U.D. DUE TO Generalized arteriosclerosis DUE TO Arteriosclerotic Heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1952 to 5 11 , 1957, that I last saw the deceased alive on 5/11 1957, and that death occurred at 4:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 128 Union St, Cumberland Md DATE SIGNED 5/12/57			
ACTUAL SIGNATURE George M. Simons M.D.		PHYSICIAN'S NAME (Type) George M. Simons, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 14, 1956	
22c. NAME OF CEMETERY OR CREMATORY Greenway Cemetery		22d. LOCATION (City, town, or county) (State) Berkley Springs, West. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Funter Funeral Home, Berkley Springs, West		ADDRESS West	
24a. REC'D BY REGISTRAR May 12 1956		24b. REGISTRAR'S SIGNATURE W. H. Frantz, M.D.	

UNITED STATES

1954

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04629

Reg. Dist. No. 6

4651

1. PLACE OF DEATH <input type="checkbox"/> COUNTY <u>Allegheny</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegheny</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Riorden Road</u>				d. STREET ADDRESS <u>Riorden Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Francis</u> <u>X. McGreevy</u>				4. DATE OF DEATH Month Day Year <u>May</u> <u>22</u> <u>19 56</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			
8. DATE OF BIRTH <u>Nov. 19-1899</u>		9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Odd jobs</u>		11. BIRTHPLACE (State or foreign country) <u>Barton, Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Michael Mc Greevy</u>			
14. MOTHER'S MAIDEN NAME <u>Anna Fboten</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. (If yes, give war or dates of service)				17. INFORMANT Address <u>(brother) John McGreevy, Westernport, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Strangulation by a leather belt.</u> (c), stating the underlying cause last, DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hung himself by a leather belt from an iron bracket.</u>					
20c. TIME OF INJURY Month, Day, Year <u>5</u> <u>22</u> <u>19 56</u> Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f. (City or town) <u>Westernport, Allegheny, Md.</u>		20g. (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Denning M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Denning M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 22-1956</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>May 24 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's</u>			
22d. LOCATION (City, town, or county) (State) <u>Westernport, Allegheny, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Harold Fudlak Piedmont</u>					
ADDRESS		24a. REC'D BY REGISTRAR DATE <u>5-24-56</u>		24b. REGISTRAR'S SIGNATURE <u>Miss Jean C Kelly</u>			

MEDICAL CERTIFICATION

about

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay occurs, the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 3

MAY 12

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4616 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04630

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Id.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>30 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Memorial Hospital</u>				d. STREET ADDRESS <u>24 Virginia Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>McLaughlin</u> Last <u>McLaughlin</u>				4. DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 24-1897</u>		9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Dept. Celanese Corp. of Am.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lonaconing, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Mc Laughlin</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Craig</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-07-2650</u>		17. INFORMANT Address <u>Mrs. Mary Atkinson, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO <u>Coronary sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Dering M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H. V. Dering M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 11-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-15-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Davis Memorial Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>		ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>May 14, 1956 W.L. Frank, M.D.</u>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, the certificate should be filed with the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



BOOK 1. 2.

1771

1771

Mem 20b 5/17/56 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Id. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 4 1/2 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
f. STREET ADDRESS 124 Hanover St.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George Frank McMullen		4. DATE OF DEATH Month Day Year May 6 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19-1887
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Plasterer		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Eckhart Mines, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Robert McMullen		14. MOTHER'S MAIDEN NAME Mary Virginia Jordon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-05-3990	
17. INFORMANT Ruth Marie McMullen		Address 117 1/2 E. 1st St., Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hemorrhage due to fractured skull 4 1/2 hrs.			
DUE TO (b) 2-678 ribs & right clavical			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Hemothorax due to fractured ribs, right side			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Apparently fell.	
20c. TIME OF INJURY 4 Months Day Year 11.15 p.m. May 5 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) May St., 143	20f. (City or town) (County) (State) Cumberland Allegany Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H.V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 7-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 9, 1956	22c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery	22d. LOCATION (City, town, or county) (State) Eckhart, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland.		24a. REC'D BY REGISTRAR May 9, 1956	24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please enclose the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU U. S.

MAY 10 1950

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										04632	
DR. TOPPER Within corporate limits										Reg. Dist. No. 4	
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE XX MARYLAND PENNSYLVANIA Bedford						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					c. LENGTH OF STAY IN 1b 12 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYNDMAN Fairhope				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			First HARRY		Middle J. MERKEL		Last		4. DATE OF DEATH Month MAY 21 Day 1956		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-17-1861		9. AGE (In years last birthday) 94 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel worker, Fairhope					11. KIND OF BUSINESS OR INDUSTRY PENNSYLVANIA			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME GEORGE MERKEL					14. MOTHER'S MAIDEN NAME MARGARET BARD						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNK					16. SOCIAL SECURITY NO. NONE		17. INFORMANT MEMORIAL HOSPITAL, MEMORIAL AVENUE				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Chronic Myocardosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21. I certify that I attended the deceased from Jan 1957 to May 21, 1956 , that I last saw the deceased alive on May 21, 1956 , and that death occurred at 11:25 P.M. from the causes and on the date stated above.										DATE SIGNED 5-21-56	
ACTUAL SIGNATURE John C. Topper M.D.					ADDRESS (Street, city or town, state) Hyndman, Pa						
PHYSICIAN'S NAME (Type) DR. J. TOPPER											
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State)			
Buried		May 24, 1956		Trinity Lutheran Cemetery, Cumberland, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Harvey J. Leigler Hyndman, Pa					24a. REC'D BY REGISTRAR DATE 5/23/1956		24b. REGISTRAR'S SIGNATURE W. R. Trout, M.D.				

MEDICAL CERTIFICATION

BUREAU N. Y.

MAY 25 1956

RECEIVED
MAY 25 1956

4661

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cresaptown c. LENGTH OF STAY IN 1b 1 mo. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Andrew Jackson Miller		4. DATE OF DEATH Month May Day 2 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 24, 1869	9. AGE (In years last birthday) 87	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer, retired		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Stemple Ridge, W. Va.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME James Wesley Miller		14. MOTHER'S MAIDEN NAME Mahala Ann Lipsomb Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO		17. INFORMANT Mrs. Nell Miller Address Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) gummed arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 to May 2, 1956 , that I last saw the deceased alive on April 20, 1956 , and that death occurred at 6:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 5-3-56					
ACTUAL SIGNATURE J. T. Johnson NAME (Type) James T. Johnson, Jr., M.D.					
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 5, 1956		22c. NAME OF CEMETERY OR CREMATORY Red House	
22d. LOCATION (City, town, or county) (State) near Oakland, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR May 4, 1956		24b. REGISTRAR'S SIGNATURE W. K. Frank, M.D.	

Outside of City Limits

Page 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 7 1900

RECEIVED
MAY 7 1900

4662

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Westernport		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Westernport	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stoney Run Road		d. STREET ADDRESS Stoney Run Road	
3. NAME OF DECEASED (Type or print) Josephine First Lovina Middle Murphy Last		4. DATE OF DEATH Month May Day 3 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 31, 1893
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Frederick Deremer		14. MOTHER'S MAIDEN NAME Mollie Dawson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Eva Metz Address Stoney Run Road - Westernport			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 27, 1956 to May 3, 1956 , that I last saw the deceased alive on May 2, 1956 , and that death occurred at 7:57 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul R. Wilson		DATE SIGNED May 5, 1956	
PHYSICIAN'S NAME (Type) Paul R. Wilson		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 6, 1956	
22c. NAME OF CEMETERY OR CREMATORY Philos Cem.		22d. LOCATION (City, town, or county) (State) Westernport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. J. Powell - Westernport Md. ADDRESS		24a. REC'D BY REGISTRAR DATE 5-5-56	
		24b. REGISTRAR'S SIGNATURE Marjorie Kelly	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SAFETY

A schematic diagram of a single neuron. The cell body (soma) contains a nucleus and is connected to a dendrite and an axon. The axon is covered by a myelin sheath. The diagram is labeled with 'A', 'B', and 'C'.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH -

04635

Reg. Dist. No. 8

4663

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MD. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b 87 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Church St.				d. STREET ADDRESS Church St.			
3. NAME OF DECEASED (Type or print) First Margaret Middle Murphy Last Murphy				4. DATE OF DEATH Month May Day 8 Year 19 56			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH Jan. 1869		9. AGE (In years last birthday) 87 yrs.	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				IF UNDER 1 YEAR Months 07 Days 00 Hours 00 Min. 00		IF UNDER 24 HRS. Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home work		10b. KIND OF BUSINESS OR INDUSTRY at her own home Lonaconing, Md.		11. BIRTHPLACE (State or foreign country) T.S.A.		12. CITIZEN OF WHAT COUNTRY? T.S.A.	
13. FATHER'S NAME Cornelius Murphy				14. MOTHER'S MAIDEN NAME Mary Farrell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Frank Bush, Pittsburg, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH sudden					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour 0 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H. V. Deming M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) H. V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 10-1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/12/1956		22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhern, Lonaconing, MD.				24a. REC'D BY REGISTRAR 5/12/56		24b. REGISTRAR'S SIGNATURE Janette M. Boal	

BUREAU V. 2

MAY 3 1922

RECEIVED

4619 CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. STREET ADDRESS Rt. # 1 La Vale Court			
3. NAME OF DECEASED (Type or print) First William Middle S. Last O'Brien				4. DATE OF DEATH Month May. Day 4 Year 1956			
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4, 1893		9. AGE (In years lost birthday) 62 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber Inspector			10b. KIND OF BUSINESS OR INDUSTRY Lumber C.		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles O'Brien				14. MOTHER'S MAIDEN NAME Sarah Stitzer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 236-03-1663		17. INFORMANT Chart.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 hepatic coma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) circulation of the liver (hypertrophy) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 day 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-30-56 , 19 56 , to 5-4-56 , 19 56 , that I last saw the deceased alive on 5-3-56 , 19 56 , and that death occurred at 5:05 A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE L. Brings				ADDRESS (Street, city or town, state) 57 Green St., Cumberland Md.		DATE SIGNED 5-4-56	
PHYSICIAN'S NAME (Type) L. Brings, M.D.				57 Green St., Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF May 6, 1956		22c. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery		22d. LOCATION (City, town, or county) (State) Elkins West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR May 7, 1956	
				24b. REGISTRAR'S SIGNATURE M. D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAY 9 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4620

CERTIFICATE OF DEATH

04637

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE W. VA. GRANT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PETERSBURG	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARRIE Middle K Last PHARES		4. DATE OF DEATH Month MAY Day 23 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 17, 1956
9. AGE (In years last birthday) yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 6 Days 6 Hours 6 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Petersburg, West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE I. PHARES		14. MOTHER'S MAIDEN NAME PAULINE RUTH MILLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Memorial Hospital, Cumberland, Maryland.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intercranial hemorrhage 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 20, 1956 to May 23, 1956 , that I last saw the deceased alive on May 23, 1956 , and that death occurred at 1:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 112 Bedford St., Cumberland Md. DATE SIGNED 5/23/56			
ACTUAL SIGNATURE R. A. Reiter		M.D. 112 Bedford St., Cumberland Md.	
PHYSICIAN'S NAME (Type) RALPH A. REITER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 25, 1956	22c. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery	22d. LOCATION (City, town, or county) (State) Petersburg, West Virginia.
23. FUNERAL DIRECTOR'S SIGNATURE Thrush Funeral Home, Petersburg, West Virginia.		24a. REC'D BY REGISTRAR DATE 5/28/56	
		24b. REGISTRAR'S SIGNATURE H. R. Frantz	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 3 1956

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Id.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Roberts St. Extended</u>		d. STREET ADDRESS <u>Roberts St. Extended</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Jacob</u> Last <u>Poole</u>		4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>19 56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 3-1823</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Firefighter helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.O.R. Ry.</u>	11. BIRTHPLACE (State or foreign country) <u>Old Town, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Samuel Poole</u>	
14. MOTHER'S MAIDEN NAME <u>Kesish Piper</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>705-05-4527</u>		17. INFORMANT <u>(wife) Llanche W. Poole, Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> <u>160X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Chronic myocarditis also had hypertension</u> (a), stating the underlying cause last. DUE TO (c) <u>Diabetes mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>several yrs</u> <u>5 years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Doring M.D.</u>		DATE SIGNED <u>May 31-1956</u>	
NAME (Type) <u>H. V. Doring M.D.</u>		DEPUTY MEDICAL EXAMINER <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 2, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Inglesmith, Pennsylvania</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox, Cumberland, Maryland.</u>		24a. REC'D BY REGISTRAR <u>June 1, 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. L. Frantz, M.D.</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used in burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1956

1956

1956

4622

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		d STREET ADDRESS 709 LEIPER ST.,	
3. NAME OF DECEASED (Type or print) First JACOB Middle S. Last POTTS		4. DATE OF DEATH Month MAY Day 24 Year 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 28, 1887
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist helper		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp	
11. BIRTHPLACE (State or foreign country) PENNA, Inglesmith		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME JONATHAN POTTS		14. MOTHER'S MAIDEN NAME AMANDA PERCELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 220-10-1917	
17. INFORMANT Mary J. Potts, 709 Leiper Street, Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO 4443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cerebro - Vascular Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 3 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 19 54 , to May 19 56 , that I last saw the deceased alive on May 24, 19 56 , and that death occurred at 2:25 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE G. Overton Himmelwright M.D.		ADDRESS (Street, city or town, State) 133 Virginia Ave, Cumberland, Md DATE SIGNED 5/25/56	
PHYSICIAN'S NAME (Type) G. Overton Himmelwright, 133 Virginia Ave., Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/27/56	22c. NAME OF CEMETERY OR CREMATORY Fairview Christ. Cem	22d. LOCATION (City, town, or county) (State) Bedford Co. Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE John J. Mafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR May 26, 1956 24b. REGISTRAR'S SIGNATURE R. R. Frantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY

BUREAU V. B. E. Q.

MAY 20 1908

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No.

04640

4623

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 7/6/50		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary			e. STREET ADDRESS Boulevard Apartments		
3. NAME OF DECEASED (Type or print) First Charles Middle William Last Purl			4. DATE OF DEATH Month May Day 3 Year 19 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/7/1890		9. AGE (In years last birthday) 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Insulation & Auto Salesman Illinois			10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME James Byron Purl			14. MOTHER'S MAIDEN NAME Elizabeth Ellingsworth		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes, Navy 1910			16. SOCIAL SECURITY NO. 305-09-3644		17. INFORMANT Address P. O. Box 599 Allegany County Infirmary Records
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis DUE TO Chronic Nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) Cerebral Hemorrhage					INTERVAL BETWEEN ONSET AND DEATH 48 hrs. ? ?
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Hemorrhage					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7/6/50 , 19 5/3/56 , to 5/3/56 , 19 5/3/56 , that I last saw the deceased alive on 5/3/56 , 19 5/3/56 , and that death occurred at 11:55 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE James E. McLean M.D.			ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED May 4, 1956		
PHYSICIAN'S NAME (Type) Dr. James E. McLean			Cumberland, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/7/56	22c. NAME OF CEMETERY OR CREMATORY Roselawn Cemetery		22d. LOCATION (City, town, or county) (State) Charleston, Illinois	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George			ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR May 5, 1956
			24b. REGISTRAR'S SIGNATURE W. R. Zant, M.D.		

RECEIVED

BURKLAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4624

CERTIFICATE OF DEATH

04641
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS Dudley Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Lillian Middle Reiber Last Reiber				4. DATE OF DEATH Month May Day 23 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 31, 1882	
9. AGE (In years last birthday) 73 yrs		IF UNDER 1 YEAR Months 7 Days 23 Hours 56 Min		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Barton, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas Mowbray				14. MOTHER'S MAIDEN NAME Jane Ann Emerson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO none		17. INFORMANT Mrs. Helen Dillon Address Lonaconing, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis Cerebral & Generalized DUE TO (c) "Daughter"						INTERVAL BETWEEN ONSET AND DEATH 2h.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Consecutive Heart Failure							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 5 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Lonaconing				20g. (County) Allegany		20h. (State) Md.	
21. I certify that I attended the deceased from July 19, 1956 to 23 May, 1956 that I last saw the deceased alive on 23 May, 1956 and that death occurred at 7:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lonaconing, Md. DATE SIGNED 5-24-56							
ACTUAL SIGNATURE George J. Richards, M.D.				PHYSICIAN'S NAME (Type) George J. Richards, Jr., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 27, 1956		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		22d. LOCATION (City, town, or county) (State) Moscow, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR May 25, 1956	
				24b. REGISTRAR'S SIGNATURE W. H. Frank, M.D.			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

MAY 28 1

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4664

CERTIFICATE OF DEATH

04642

Reg. Dist. No. 8

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		STATE MD.		COUNTY Allegany			
CITY (if outside corporate limits, write RURAL and give nearest town) Lonaconing		LENGTH OF STAY (in this place) 64		CITY (if outside corporate limits, write RURAL and give nearest town) Lonaconing			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Jackson street				STREET ADDRESS (if rural give location) Jackson Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
Bearl L Richardson				5/30/1956			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
Female		White		Widowed		1/20/1892	
						9. AGE last birthday	
						64	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housework				Own Home		Lonaconing, MD.	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles Devault				Fredrica Metz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
NO				NONE		MRS. JOHN DONALDSON, Daughter.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				Lonaconing, MD.			
ANTECEDENT CAUSE(S) DUE TO (B)				Interval between ONSET and DEATH			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)				17 mo.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				2 mo.			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1954, 1955, to 5/30, 1956; that I last saw the deceased alive on 5/31, 1956, and that death occurred at 11 A.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
George Richardson				6/1/56			
23. BURIAL, CREMATION, REMOVAL (Specify)				NAME OF CEMETERY OR CREMATORY			
Burial				Oak Hill Cemetery			
DATE THEREOF				LOCATION (City, town, or county)			
6/2/1956				Lonaconing, MD.			
24. REC'D BY REGISTRAR				25. FUNERAL DIRECTOR'S SIGNATURE			
REGISTRAR'S SIGNATURE				ADDRESS			
DATE 6/2/56				George Eichhorn, Lonaconing, MD.			

W. A. GORDON

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4665

CERTIFICATE OF DEATH

Reg. Dist. No. 8

04643

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nikep		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nikep	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Abraham Lincoln Roberts		4. DATE OF DEATH May 30 Day 30 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1926 Aug. 9
9. AGE (In years last birthday) 29 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Filt'r Plant Operater		10b. KIND OF BUSINESS OR INDUSTRY Paper Mill	
11. BIRTHPLACE (State or foreign country) Barton-Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Roberts		14. MOTHER'S MAIDEN NAME Hannah Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-8048	
17. INFORMANT John Roberts		Address Barton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral & Generalized Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 18 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1953 to 30 May 1956 , that I last saw the deceased alive on 29 May 1956 , and that death occurred at 3:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George J. Richards		ADDRESS (Street, city or town, state) 517 Main, Farmington, Md.	
PHYSICIAN'S NAME (Type) George J. Richards		DATE SIGNED 5/30/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/2/56	
22c. NAME OF CEMETERY OR CREMATORY Laurel Hill		22d. LOCATION (City, town, or county) (State) LOSCOW Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. J. Biral		ADDRESS Westernport, Md.	
24a. REC'D BY REGISTRAR 6/2/56		24b. REGISTRAR'S SIGNATURE Jannette M. Boal	



18 10/10/10

10 10/10/10

04644

Reg. Dist. No.

4625

1. PLACE OF DEATH a. COUNTY <u>Allegany</u>	2. USUAL RESIDENCE (Where deceased lived. If inst'lution; Residence before admission) a. STATE <u>MD.</u>	b. COUNTY <u>Allegany</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	c. LENGTH OF STAY IN lb <u>6 months</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Flintstone</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. at Sacred Heart Hospital</u>	d. STREET ADDRESS <u>Green Ridge Camp.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Zed Edwin Rodgers</u>	4. DATE OF DEATH Month Day Year <u>May 4 1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>June 11-1913</u>	9. AGE (In years last birthday) <u>42</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cottage Master, Boys Forestry Camp.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Forestry Camp.</u>	11. BIRTHPLACE (State or foreign country) <u>Wards, S. Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Zed Rodgers</u>	14. MOTHER'S MAIDEN NAME <u>Unknown</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u>	16. SOCIAL SECURITY NO. <u>209-1-4131</u>	17. INFORMANT <u>(wife) Sarah Rodgers</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery occlusion</u> DUE TO (b) <u>Coronary sclerosis</u> DUE TO (c) <u></u>	INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NALDISEASE CONDITION GIVEN IN PART I (c)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>
20f. (City or town) <u></u>	(County) <u></u>	(State) <u></u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .		
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 5-1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/8/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>
22d. LOCATION (City, town, or county) <u>Woodruff, S. Carolina</u>	(State) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George Cumberland, Maryland</u>	24a. REC'D BY REGISTRAR <u>May 7, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>W. E. Bank, M.D.</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please execute the certificate, inserting the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAY 6

RECEIVED

4626

CERTIFICATE OF DEATH

04645

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. STREET ADDRESS 52 Marion Street	
3. NAME OF DECEASED (Type or print) First William Middle P. Last Rollins		4. DATE OF DEATH Month May Day 2 , Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/15/1869
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR: Months 8 Days 15 Hours 0 Min. 0	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Drayman - Hauling		11b. KIND OF BUSINESS OR INDUSTRY Hauling	
12. BIRTHPLACE (State or foreign country) Pratt, Maryland		13. CITIZEN OF WHAT COUNTRY? U. S. A.	
14. FATHER'S NAME Thomas J. Rollins		15. MOTHER'S MAIDEN NAME Sarah E. Hanna	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		17. SOCIAL SECURITY NO. None	
18. INFORMANT Allegany County Infirmary Records		Address P.O. Box 599	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 400.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Arteriosclerosis DUE TO Chronic Nephritis (c) Total Blockage		INTERVAL BETWEEN ONSET AND DEATH Sudden ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/16/53 , 19____, to 5/2/56 , 19____, that I last saw the deceased alive on 5/2/56 , 19____, and that death occurred at 10:23A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 5/2/56	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/4/56	22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR May 3, 1956		24b. REGISTRAR'S SIGNATURE Walter R. Lantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. C.

MAY 2 1954

RECEIVED
MAY 2 1954

DR. R. J. WMS.

4627 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 7 HRS. 30 MINS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 307 HELEN ST.	
3. NAME OF DECEASED (Type or print) ROGER First Middle Last		4. DATE OF DEATH MAY 13, 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 23, 1914
9. AGE (In years last birthday) 41 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent		10b. KIND OF BUSINESS OR INDUSTRY Insurance Company	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN W. ROW		14. MOTHER'S MAIDEN NAME BOBO IVA MANN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL-MEMORIAL & WARWICK AVES.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/30/56, 19, to 5/13/56, 19, that I last saw the deceased alive on 5/13/56, 19, and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. J. Williams M.D.		DATE SIGNED 5/13/56	
PHYSICIAN'S NAME (Type) R. J. Williams		ADDRESS (Street, city or town, state) Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 16, 1956	22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Maryland.		24a. REC'D BY REGISTRAR May 14, 1956	
		24b. REGISTRAR'S SIGNATURE W. L. Grant, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 51 07-1117

94 1 1

112 11

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04647

Reg. Dist. No.

4628

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Allegany 	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 		c. LENGTH OF STAY IN 1b 55 Yrs. 	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 625 Latterson Ave. 		d. STREET ADDRESS 625 Latterson Ave. 	
3. NAME OF DECEASED (Type or print) First Otto Middle Henry Last Ruehl 		4. DATE OF DEATH Month May Day 10 Year 19 56 	
5. SEX Male 	6. COLOR OR RACE White 	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12-1900
9. AGE (In years last birthday) 55 yrs. 		IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired sewer worker-Queen City 		10b. KIND OF BUSINESS OR INDUSTRY Sewer Co. 	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland 		12. CITIZEN OF WHAT COUNTRY? U.S.A. 	
13. FATHER'S NAME William Ruehl 		14. MOTHER'S MAIDEN NAME Sophia Schneider 	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No 		16. SOCIAL SECURITY NO. 214-05-5834 	
17. INFORMANT (wife) Lucy Mae Ruehl, Cumberland, Md. 		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemoptysis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ruptured dissecting aneurism of the aorta DUE TO (c) into the lungs also had cardiac hypertrophy (marked) 		INTERVAL BETWEEN ONSET AND DEATH sudden 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Deming M.D. 		DATE SIGNED	
EXAMINER'S NAME (Type) H. V. Deming M.D. 		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER May 10-1956 	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 	22b. DATE THEREOF May 12, 1956 	22c. NAME OF CEMETERY OR CREMATORY Sts. Peter & Paul Cemetery 	
		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland 	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Maryland. 		24a. REC'D BY REGISTRAR May 12, 1956 	
		24b. REGISTRAR'S SIGNATURE W. L. Frank, M.D. 	

1 Within corporate limits

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAY

1915

4652

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
c. LENGTH OF STAY IN life life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 40 Wright St.		d. STREET ADDRESS 40 Wright St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First OSCAR Middle S. Last SAVAGE		4. DATE OF DEATH Month May Day 5 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-18-1904
9. AGE (In years lost birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service man		10b. KIND OF BUSINESS OR INDUSTRY Potomac Edison Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George M. Savage		14. MOTHER'S MAIDEN NAME Hattie V. Murphy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-10-5075	
17. INFORMANT Mrs. Vivian E. Savage, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Dilatation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chr Myocardial Infarction DUE TO (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH Sudden 6 mo Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 9 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 22, 1923 to May 5, 1956 that I last saw the deceased alive on Apr 30, 1956 , and that death occurred at 4:00 PM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Frostburg, Md DATE SIGNED May 7 1956	
ACTUAL SIGNATURE Wm C Lane M.D.			
PHYSICIAN'S NAME (Type) Wm C Lane			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-8-56	
22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		24a. REC'D BY REGISTRAR 5-9-56	
		24b. REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. BUREAU

MAY 15 1930

RECEIVED
MAY 15 1930

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4629 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04649

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>ampshire</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Roanoke</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.C.A. in the Memorial Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Larry</u> Middle <u>Donald</u> Last <u>Saville</u>				4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED: <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 23-1936</u>	9. AGE (In years last birthday) <u>19</u> yrs.	IF UNDER 1 YEAR Months <u>19</u> Days <u>19</u> Hours <u>56</u> Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Augusta, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Roy L. Saville</u>				14. MOTHER'S MAIDEN NAME <u>Dollie Snyder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>234-56-5356</u>		17. INFORMANT Address <u>(father) Roy L. Saville, Roanoke, W. Va.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u>							
DUE TO (b) <u>Crushed skull</u>							
DUE TO (c) <u>Auto accident in W. Va.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver lost control of auto, making a turn, auto hit steel post & tree.</u>			
20c. TIME OF INJURY Month, Day, Year <u>12-20-56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway 1.50</u>		20f. (City or town) (County) (State) <u>Roanoke ampshire W. Va.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Doming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Doming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 19-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 21, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salem Methodist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Slanesville, West Virginia.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. McKee, Augusta, West Virginia.</u>				24a. REC'D BY REGISTRAR <u>May 19, 1956 W. L. Frantz, M.D.</u>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2000 1.1

MAY 2 1999

RECEIVED

4630

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>	
c. LENGTH OF STAY IN lb <u>12 dys.</u>		d. STREET ADDRESS <u>420 Williams St.,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp.,</u>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>SCHAFER</u> Last <u>SCHAFER</u>		4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 13, 1874</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic help</u>	11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>Mathias Schaffer</u>	
14. MOTHER'S MAIDEN NAME <u>Catherine Highland</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No,</u>	
16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Mr. Albert Schaffer 420 Williams St., Cumb. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Maemia</u> <u>3.71X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Hemorrhage-R-18 days</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from <u>Apr. 15, 1956</u> to <u>May 1, 1956</u> that I last saw the deceased alive on <u>Apr. 30, 1956</u> , and that death occurred at <u>2:20A. M.</u> from the causes and on the date stated above.	
ADDRESS (Street, city or town, state) _____		DATE SIGNED _____	
ACTUAL SIGNATURE <u>Clay E. Durrett</u> M.D.		236 Virginia Ave.,	
PHYSICIAN'S NAME (Type) <u>Clay E. Durrett M.D.</u>		<u>Cumberland, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/3/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Maryland</u>	
24a. REC'D BY REGISTRAR <u>May 3, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Walter R. Lantz, M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 4 1956

RECEIVED
BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

DR. HIMMELWRIGHT

4631

CERTIFICATE OF DEATH

04651

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS R.F.D. #3 Bedford Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First IDA Middle I. Last SEE				4. DATE OF DEATH Month MAY Day 4 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 29 1866	
9. AGE (in years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA Moorefield	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CHARLES STICKLEY				14. MOTHER'S MAIDEN NAME BELLE Brill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Heart Failure DUE TO Cerebral Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced Age DUE TO (c) Advanced Age				INTERVAL BETWEEN ONSET AND DEATH 24 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 1956 to May 1956 , that I last saw the deceased alive on May 4 1956 , and that death occurred at 3:22 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Ida See				DATE SIGNED 5/5/56			
PHYSICIAN'S NAME (Type) G. Overton Himmelwright, M.D.				133 Virginia Ave., Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5/6/56		22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery	
22d. LOCATION (City, town, or county) (State) Cumberland, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR May 5, 1956	
24b. REGISTRAR'S SIGNATURE W.R. Thant, M.D.							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAY 9 1956
BUREAU V. S.

4653

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution - Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			
c. LENGTH OF STAY IN 1b life							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 246 E. Main St.				d. STREET ADDRESS 246 E. Main St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last SEIFARTH				4. DATE OF DEATH Month May Day 18 Year 1956			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-4-1875	
9. AGE (In years last birthday) 81 yrs		IF UNDER 1 YEAR Months 8 Days 18 Hours 56		IF UNDER 24 HRS Months 8 Days 18 Hours 56			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Ernest C. Seifarth				14. MOTHER'S MAIDEN NAME Elizabeth Kohl			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type, no, or unknown) (If yes, give war or dates of service) none				16. SOCIAL SECURITY NO. Miss Lula Seifarth, Frostburg, Md.			
17. INFORMANT Miss Lula Seifarth, Frostburg, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio sclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Frostburg				20g. (County) Md.		20h. (State) Md.	
21. I certify that I attended the deceased from May 18, 1956 to May 18, 1956 , that I last saw the deceased alive on May 18, 1956 , and that death occurred at 10:10 A.M. , from the causes and on the date stated above							
ACTUAL SIGNATURE W. O. Mc Lane M.D.				ADDRESS (Street, city or town, state) Frostburg Md.			
DATE SIGNED May 19/1956							
PHYSICIAN'S NAME (Type) W. O. Mc Lane							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-21-56		22c. NAME OF CEMETERY OR CREMATORY Zion Evan. Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 5-28-56	
				24b. REGISTRAR'S SIGNATURE Mr. Harvey N. Roe			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURTON & S.

JAY - 3 - 1910

RECEIVED

4632

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
c. LENGTH OF STAY IN 1b <u>25 Yrs</u>				d. STREET ADDRESS <u>607 Washington St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>307 Washington St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Alexander</u> Middle <u>Sloan</u> Last <u>Sloan</u>			4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1956</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 11, 1891</u>	9. AGE (In years last birthday) <u>64</u> yrs.	10. IF UNDER 1 YEAR Months <u>64</u> Days <u>64</u> Hours <u>64</u> Min.	11. IF UNDER 24 HRS Months <u>64</u> Days <u>64</u> Hours <u>64</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Glass Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Matthew Sloan</u>				14. MOTHER'S MAIDEN NAME <u>Mary Connolly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214 32 3071</u>		17. INFORMANT <u>Mrs Flora Sloan</u> Address <u>Cumberland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u> DUE TO <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Short</u> DUE TO (c) <u>time</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Short</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3. 3. 1946</u> to <u>5. 7. 1956</u> that I last saw the deceased alive on <u>5-1-1956</u> , and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. F. Williams</u> M.D.				ADDRESS (Street, city or town, state) <u>Cumberland</u> DATE SIGNED <u>5-8-56</u>			
PHYSICIAN'S NAME (Type) <u>W. F. Williams, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/9/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc.</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>May 9, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. F. Williams, M.D.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 10 1956

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04654

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4633

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Bedford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>10 1/2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Sacred Heart Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Gary</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>1956</u>	
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 17-1942</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Centerville School-Cumberland, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Allen R. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Blanch Ware</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>(father) Allen R. Smith, R.F.D. #3 Cumberland</u>		Address <u>Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital heart disease</u> DUE TO (b) <u>Congenital heart defect.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>13 yrs.</u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>754.4</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 31, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Grove Meth. Cem. Allegheny County, Maryland</u>		22d. LOCATION (City, town, or county) (State) <u>Allegheny County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Rafer, Cumberland, Maryland</u>		24a. REC'D BY REGISTRAR <u>May 30, 1956 W. K. Prantz, M.D.</u>	
24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

JUN 4 1955

NOV

RECEIVED

4634

CERTIFICATE OF DEATH

Reg. Dist. No.

04655

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>			
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>68yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>26 Grand Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>T.</u> Last <u>Storer</u>				4. DATE OF DEATH <u>May</u> Month <u>21</u> , Day <u>19</u> Year <u>56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5, 1880</u>		9. AGE (In years last birthday) <u>76</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Juv Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Textile Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Staffordshire, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Storer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Clark</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-07-2294</u>		17. INFORMANT Address <u>Grace H. Storer 26 Grand Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>400.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>May 15, 1956</u> to <u>May 21, 1956</u> , that I last saw the deceased alive on <u>May 15, 1956</u> , and that death occurred at <u>2:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clay M. Durrett</u> M.D.				ADDRESS (Street, city or town, state) <u>Cumberland Md</u> DATE SIGNED <u>5/22/56</u>			
PHYSICIAN'S NAME (Type) <u>Clay M. Durrett</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-24-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James P. Scamelli</u> ADDRESS <u>Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>May 24, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Hank</u> M.D.	

BUKHAU V. S.

MAY 5 1

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. VAN ORMER
CORBAN PAPER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04656

4635

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY HAMPSHIRE					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROMNEY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SAMUEL Middle SULSER Last SULSER				4. DATE OF DEATH Month MAY Day 14 Year 1956					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH KK AUG. 12 11, 1888		9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee of W. Va. State Roads Commission				10b. KIND OF BUSINESS OR INDUSTRY WEST VIRGINIA		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA			
13. FATHER'S NAME WILLIAM H. SULSER				14. MOTHER'S MAIDEN NAME MARGARET F. BOWMAN				12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, MEMORIAL AVENUE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute, Postmenstrual DUE TO with Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 13 May 1956 , to 14 May 1956 , that I last saw the deceased alive on 14 May 1956 , and that death occurred at 11:55 PM , from the causes and on the date stated above.									
ACTUAL SIGNATURE W. Alfred Van Ormer M.D.				ADDRESS (Street, city or town, state) Cumberland, Md				DATE SIGNED 15 May 56	
PHYSICIAN'S NAME (Type) DR. W.A. VAN ORMER									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 18, 1956		22c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		22d. LOCATION (City, town, or county) (State) Romney, West Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE Keith Shaffer				ADDRESS Romney, Md		24a. REC'D BY REGISTRAR May 16, 1956		24b. REGISTRAR'S SIGNATURE J.R. Hantz, M.D.	

U.S. AIR FORCE

AWP

RECEIVED
JAN 25 1951

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04657

4636

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>115 Offutt St.</u>		d. STREET ADDRESS <u>115 Offutt St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Luther</u> Last <u>Swandol</u>		4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 4-1903</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B&O.R.Ry.</u>	
11. BIRTHPLACE (State or foreign country) <u>Hancock, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Swandol</u>		14. MOTHER'S MAIDEN NAME <u>Tida Gladhill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>017-10-1453</u>	
17. INFORMANT <u>(wife) Hannah J. Swandol, Cumberland, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pharyngeal & Laryngeal hemorrhage</u> DUE TO (b) <u>22 (short) caliber rifle bullet in neck</u> DUE TO (c) <u>below chin. (suicide)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Shot himself with a 22 caliber rifle bullet at home.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot himself with a 22 caliber rifle bullet at home.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>11</u> a. m. <u>5-20</u> 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Cumberland Allegany Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. L. Fanning M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Denning M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <u>May 29-1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 1, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkhead Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Parkhead, Washington Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Maryland.</u>		24a. REC'D BY REGISTRAR <u>May 30, 1956 W. R. Frantz, M.D.</u>	
		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please enclose the certificate with the ward "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. B.

RECEIVED
BUREAU V. B.

4637

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>64 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>182 Thomas St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jemima</u> <u>Troxell</u>				4. DATE OF DEATH Month Day Year <u>5</u> <u>18</u> <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 14, 1892</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Nelson Robinette</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth M. White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Laura White, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Maemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>15 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar. 15, 1956</u> to <u>Apr. 18, 1956</u> , that I last saw the deceased alive on <u>Apr. 14, 1956</u> , and that death occurred at <u>3:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cumberland Md</u> DATE SIGNED <u>5/20/56</u> ACTUAL SIGNATURE <u>Clay E. Durrett</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>CLAY E. DURRETT</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>May 1, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park Cumberland, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Bennett</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>May 21, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Frank, M.D.</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

W. A. DUNN

AY 1500

1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04659

DR. WEISMAN

4638

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 23 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 215 GREENE STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELTON Middle F. VAN SANT Last		4. DATE OF DEATH Month MAY Day 8 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 4, 1888
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY FOOTE		14. MOTHER'S MAIDEN NAME MINNIE YOUNG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPOSTATIC PNEUMONIA DUE TO UREMIA → 23 days DUE TO NEPHROSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIO VASCULAR (c) RENAL DISEASE		INTERVAL BETWEEN ONSET AND DEATH 7 days 4 yr 10 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS 10 yr. CHOLECYSTITIS + CHOLELITHIASIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 8, 1956 to May 8, 1956 that I last saw the deceased alive on May 8, 1956 and that death occurred at 10:45 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 59 GREENE ST Cumberland Md	
ACTUAL SIGNATURE S. G. Weisman M.D.		DATE SIGNED 5/16/56	
PHYSICIAN'S NAME (Type) S. G. Weisman M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 11, 1956	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE May 11, 1956	
		24b. REGISTRAR'S SIGNATURE W. R. Dancy, MD	

RECEIVED
MAY 14 1964
U.S. AIR FORCE

4554

CERTIFICATE OF DEATH

04660

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
c. LENGTH OF STAY IN 1b <u>Lifetime</u>		d. STREET ADDRESS <u>215 Welsh Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>215 Welsh Hill</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Ward</u> Last <u>Ward</u>		4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16th, 1876</u> 80 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Consolidation, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>J.S.A.</u>	
13. FATHER'S NAME <u>Hugh Freal</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Gallagher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Joseph Murphy, Frostburg, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>Arterio Sclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>4 yrs</u> <u>?</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> , 1953, to <u>May 18</u> , 1956, that I last saw the deceased alive on <u>May 18</u> , 1956, and that death occurred at <u>2:00 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Frostburg Md</u> DATE SIGNED <u>May 19 1956</u> ACTUAL SIGNATURE <u>W O McLane</u> M.D. <u>W O McLane</u> PHYSICIAN'S NAME (Type) <u>W O McLane</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-21-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Michael's Cemetery Frostburg</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Burial H. Montague</u>		24a. REC'D BY REGISTRAR <u>5-21-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Will Nancy V. Ruz</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

MAY 23 1950

RECEIVED

4666

CERTIFICATE OF DEATH

Reg. Dist. No.

2

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. # 2 Flintstone,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. # 2 Flintstone			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Murley's Branch				d. STREET ADDRESS Murley's Branch			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First NINA Middle MAY Last WENTLING		4. DATE OF DEATH Month May Day 1 Year 19 56					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 17, 1873	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Murley's Branch, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John P. Long				14. MOTHER'S MAIDEN NAME Amanda Robinette			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Arch Wentling Rt. # 2 Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1946 to May 2, 1956 that I last saw the deceased alive on April 19, 1956 , and that death occurred at 12:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James T. Johnson, Jr., M.D.				DATE SIGNED Cumberland, Md 5-3-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/3/56		22c. NAME OF CEMETERY OR CREMATORY Green Meadow Cemetery		22d. LOCATION (City, town, or county) (State) Murley's Branch, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR May 3, 1956	
				24b. REGISTRAR'S SIGNATURE Miss L. Bender			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 7 1911

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04662

4639

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Hamshire</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenland</u>		c. LENGTH OF STAY IN 1b <u>40 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Green Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>T.</u> Last <u>Whetzel</u>				4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 3-1892</u>		9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Womers Co. Inc.</u>		11. BIRTHPLACE (State or foreign country) <u>Oldsfield, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Whetzel</u>				14. MOTHER'S MAIDEN NAME <u>Mally Sherman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>232-10-5567</u>		17. INFORMANT (wife) <u>Guenna Kessell Whetzel</u> Address <u>Spring, W. Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock, trauma & abdominal hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>a crushed pelvis, avulsion of left lower leg & buttock, compound comminuted fracture, left elbow.</u> DUE TO (c) <u>leg & buttock, compound comminuted fracture, left elbow.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Transferring crane on flat car from yard to</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) <u>Struck by crane while working on flat car. Was caught between cab & flat car.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>5-24</u> a. m. <u>1956</u> p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Womers Co. Plant, Green Spring</u>		20f. (City or town) <u>Hamshire</u> (County) <u>W. Va.</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>A. V. Dering M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>A. V. Dering M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 24-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 27, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Glen Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Greenspring, West Virginia.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Combs Funeral Home, Romney, West Virginia.</u>				24a. REC'D BY REGISTRAR <u>May 25, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>A. V. Dering M.D.</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please execute the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MAY 23 1966

DEPT. OF JUSTICE

CERTIFICATE OF DEATH

Reg. Dist. No. 2

4667

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL, NR, LINTSTONE</u>		c. LENGTH OF STAY IN 1b <u>YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RES. TRUST STATE H. LINTSTONE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LDA</u> First <u>LINT</u> Middle <u>IA</u> Last <u>CAPO</u>		4. DATE OF DEATH <u>May 13, 1956</u> Month <u>May</u> Day <u>13</u> Year <u>19</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1876</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Woodmont, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT LEE HILL</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH TICAHOL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>DR. J. H. PUGH, L.A. CLINIC, 1111 SRY</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma breast</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastatic</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 12, 1954</u> to <u>May 13, 1956</u> , that I last saw the deceased alive on <u>5/12</u> , 195 <u>6</u> , and that death occurred at <u>9:10</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>George M. Brown M.D. 124 Union St. Cumberland, Md.</u> <u>5/14/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 11, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>		24a. REC'D BY REGISTRAR <u>May 15, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Anna L. Bunker</u>			

MEDICAL CERTIFICATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

340

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04664

CERTIFICATE OF DEATH

Reg. Dist. No.

4640

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS RT.#2 WILLIAMS ROAD			
3. NAME OF DECEASED (Type or print) First SHAY Middle WIGFIELD Last				4. DATE OF DEATH Month MAY Day 30 Year 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/26/1891	9. AGE (In years last birthday) yrs 64	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm owner		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA Fulton Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander WIGFIELD				14. MOTHER'S MAIDEN NAME Mary Jane Potts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Primary Carcinoma of Stomach to metast. liver DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3-4 mo.						INTERVAL BETWEEN ONSET AND DEATH 3-4 mo.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 14 , 19 56 , to APRIL 29 , 19 56 , that I last saw the deceased alive on 12 , and that death occurred at 9:19 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 115 So. Centre St. Cumberland Md. DATE SIGNED 6-1-56 ACTUAL SIGNATURE DR. A.J. MIRKIN PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/1/56		22c. NAME OF CEMETERY OR CREMATORY Mt. Herman		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR June 1, 1956		24b. REGISTRAR'S SIGNATURE W. K. Hantz, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

4668

CERTIFICATE OF DEATH

Reg. Dist. No.

10

| | | | | | | | |
|---|----------------------------------|---|--------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mt. Savage, rural | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mt. Savage, rural | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print)
First SUSAN Middle A. Last WINEBRENNER | | | | 4. DATE OF DEATH
Month May Day 24 Year 1956 | | | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4-29-1880 | 9. AGE (In years last birthday)
76 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housework | | 10b. KIND OF BUSINESS OR INDUSTRY
own home | | 11. BIRTHPLACE (State or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Cyrus Hutzell | | | | 14. MOTHER'S MAIDEN NAME
Louise Camer | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
213-01-4667A | | 17. INFORMANT
Wm. B. Winebrenner, Mt. Savage, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Myocardosis
4 due to DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from January 1956 to May 24, 1956 , that I last saw the deceased alive on May 24, 1956 , and that death occurred at 6:50 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
Johell Joppa | | M.D. Hyndman | | ADDRESS (Street, city or town, state)
Eckhart Md. | | DATE SIGNED
5-26-56 | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5-27-56 | | 22c. NAME OF CEMETERY OR CREMATORY
Porter Cemetery | | 22d. LOCATION (City, town, or county) (State)
Eckhart Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. R. Durst, Frostburg, Md. | | | | 24a. REC'D BY REGISTRAR
DATE 5-28-56 | | 24b. REGISTRAR'S SIGNATURE
Veronica M. Dermitt | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

4641

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE WEST VIRGINIA b. COUNTY Hampshire | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
02 CUMBERLAND | | | | c. LENGTH OF STAY IN lb
6 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
60 MEMORIAL HOSPITAL | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SPRINGFIELD 852-3 | | | |
| | | | | d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First WILLIAM Middle L. Last WOODSON | | | | 4. DATE OF DEATH
Month MAY Day 15 Year 1956 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
MARCH 9 1876 80 YRS | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FARMING | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Farmer | | 9. AGE (In years last birthday) 80 YRS | |
| | | | | 11. BIRTHPLACE (State or foreign country)
WEST VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY
USA | |
| 13. FATHER'S NAME
JOHN T. WOODSON | | | | 14. MOTHER'S MAIDEN NAME
MARY C. ADAMS | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
MEMORIAL HOSPITAL—MEMORIAL AVENUE Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma liver; original 199.9
DUE TO site undetermined
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 month |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
arteriosclerosis Heart Disease | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9 May 1956 to 15 May 1956 that I last saw the deceased alive on 14 May 1956 , and that death occurred at 4:30 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) W. Alfred Van Ormer, M.D., Cumberland, Md. DATE SIGNED 15 May 56 | | | | | | | |
| ACTUAL SIGNATURE W. Alfred Van Ormer M.D. Cumberland, Md. DATE SIGNED 15 May 56 | | | | | | | |
| PHYSICIAN'S NAME (Type) DR. W.A. VAN ORMER | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
May 17 1956 | | 22c. NAME OF CEMETERY OR CREMATORY
Ft. Ashby Cemetery | | 22d. LOCATION (City, town, or county) (State)
Ft. Ashby, W. Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Keith Shaffner | | | | ADDRESS
Romney, W. Va. | | 24a. REC'D BY REGISTRAR
May 16, 1956 24b. REGISTRAR'S SIGNATURE
W.R. Frantz, M.D. | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page No. 12

MASSACHUSETTS
DEPARTMENT OF HEALTH
BOSTON
MAY 18 1958
RECEIVED

BUREAU V. S.

MAY 18 1958

RECEIVED

4642

CERTIFICATE OF DEATH

Reg. Dist. No.

4

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
2 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL, MEMORIAL AVE. | | | | d. STREET ADDRESS
227 S. SMALLWOOD ST. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) MR. RALPH W. YOUNG | | | | 4. DATE OF DEATH MAY 15 1956 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH March 19, 1879 | |
| 9. AGE (In years last birthday) 77 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Machinist | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Silk Co. | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
WILLIAM YOUNG | | | | 14. MOTHER'S MAIDEN NAME
ANNIE MC KEE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 214-07-4914 | | | |
| 17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND MD. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Peritonitis - generalized
DUE TO Carcinoma of stomach perforating
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) 151X
(c) | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 3 day | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign hypertrophy of prostate | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 3-7-1956 to 5-15-1956 that I last saw the deceased alive on 5-15-1956 and that death occurred at 9:00AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Wm. F. Williams, M.D. | | | | ADDRESS (Street, city or town, state) 122 S. Centre St. Cumberland, Md. | | | |
| PHYSICIAN'S NAME (Type) Wm. F. Williams, M.D. | | | | DATE SIGNED 5-15-56 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5-17-1956 | | 22c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cem. | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles L. George | | | | ADDRESS
Cumberland, Md. | | | |
| 24a. REC'D BY REGISTRAR
May 19, 1956 | | | | 24b. REGISTRAR'S SIGNATURE
W.L. Frank, M.D. | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6022

WEST VIRGINIA STATE DEPARTMENT OF HEALTH—BUREAU OF VITAL RECORDS

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

BUREAU V. S.

MAY 18 1956

RECEIVED